DCH/LDN-508 (07/04)

Michigan Department of Community Health
Board of Dentistry
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918

DENTAL HYGIENE ENDORSEMENT INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Dentistry. Questions regarding your application can be directed to the Michigan Board of Dentistry at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

GENERAL INSTRUCTIONS

1. The Michigan Board of Dentistry may issue a registration by endorsement to an applicant who is currently licensed in another state if that state's licensure requirements are substantially equivalent to those required in Michigan and the applicant has been licensed in that state for at least two (2) years.

2. Please mark the appropriate type of registration/certification for which you are applying. Read all instructions carefully and answer all questions on the application including providing details on a separate sheet if necessary. Failure to correctly complete the application in its entirety may delay the processing of your application. You must provide a complete listing of **all states** (excluding temporary licenses) in which you have **ever** held a dental hygiene license.

3. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.

4. You are required by law to notify this office within 30 days if:

   a. **YOU CHANGE YOUR NAME** - Send a letter advising us of the name change. Please be sure to include your license number and the name under which you are currently licensed as well as your new name. This information can be faxed to (517) 373-2179.

   b. **YOU CHANGE YOUR ADDRESS** - Send correct address information including street number, street name, apartment number, P.O. Box or R.D. number, city, state and ZIP Code. Be sure to include your license number in the correspondence. This information can be faxed to (517) 373-2179.

5. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Dentistry in writing to request a refund.

REGISTRATION BY ENDORSEMENT INSTRUCTIONS

1. Complete the application for registration in its entirety and submit it with the required fee. Applications submitted without the licensing fee will be returned.

2. You must complete **PART I** of the enclosed Endorsement Certification form and mail it to the state in which you were originally licensed by examination for completion of **PART II** by that state. **Contact your original state of licensure for information regarding fees charged for this service.**

3. In addition to the Endorsement form from your original state of licensure, a Verification of Licensure form must be forwarded to this office **from** EACH additional state in which you hold or have ever held a dental hygiene license. The Verification of Licensure form may be duplicated. You may wish to check with the other state(s) as a fee is usually charged for this service.

4. Submit a FINAL, OFFICIAL transcript of grades from your dental hygiene program. **The transcript must be submitted directly to this office from your school.**

5. Contact the National Board of Dental Hygiene Examiners, 211 E. Chicago Avenue, Ste 1846, Chicago, Illinois 60611, telephone (312) 440-2678, or website: www.ada.org/prof/ed/testing/natboard, to request that an OFFICIAL REPORT of your National Board scores be sent directly to the Board office. (Copies of examination scores are not acceptable.)

6. Dental Hygienists who have been licensed in another state for less than 2 years: If you have taken a regional or state examination other than NERB, please arrange to have the Regional/State Examination booklet and your scores submitted directly to this office from the testing agency. The examination you took will be evaluated by the Michigan Board of Dentistry to determine if it is equivalent to the NERB. You will be notified of the Board's decision either to accept the examination you took or to require that you pass all or part of the NERB examination.

7. Dental Hygienists who have been licensed in another state for 2 or more years: If you have taken a regional or state examination other than NERB, please arrange to have the Regional/State Examination scores submitted directly to this office from the testing agency.

REGISTERED DENTAL HYGIENIST CERTIFICATION TO ADMINISTER LOCAL ANESTHESIA

1. Submit a completed application and proper fee. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for certification within two years from the date of filing the application, the application and fee are no longer valid.

2. Submit the verification of completion of training. The verification can be a certificate of completion from an approved continuing education program or completion of the Verification of Local Anesthesia Administration Training form (attached). The course should include at least 15 hours of didactic instruction and 14 hours of clinical experience in theory of pain control; selection of pain control modalities; anatomy; neurophysiology; pharmacology of local anesthetics; pharmacology of vasoconstrictors; psychological aspects of pain control; systemic complications; techniques of maxillary anesthesia; techniques of mandibular anesthesia; infection control and local anesthesia medical emergencies.

3. Submit verification of current certification in basic or advanced cardiac life support. The verification should be a notarized copy of your current certification.

4. Submit proof of completion of the Northeast Regional Board Examination (NERB) in local anesthesia within 18 months of completion of the course work. If you have already taken the examination, the Board office already has the scores. If you have not taken the examination, contact the office of the Northeast Regional Board of Examiners, 8484 Georgia Avenue, Suite 900, Silver Spring, MD 20910, telephone (301) 563-3300, or website: www.nerb.org, for an application and information on the examination dates and locations.

5. If you have taken a regional or state examination in local anesthesia other than NERB, please arrange to have the Regional/State Examination booklet (test outline) submitted directly to this office from the testing agency. The examination you took will be evaluated to determine if it is equivalent to the NERB. You will be notified of the Board's decision either to accept the examination you took or to require that you pass the NERB examination.

6. Upon completion of all requirements, a permanent certificate in the administration of local anesthesia will be issued. It will remain active as long as your dental hygiene license is active.

REGISTERED DENTAL HYGIENIST CERTIFICATION TO ADMINISTER NITROUS OXIDE ANALGESIA

1. Submit a completed application and proper fee. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for certification within two years from the date of filing the application, the application and fee are no longer valid.

2. Submit the verification of completion of training. The verification can be a certificate of completion from an approved continuing education program or completion of the Verification of Nitrous Oxide Analgesia Training form (attached). The course should include at least 4 hours of didactic instruction and 4 hours of clinical experience in nitrous oxide analgesia medical emergency techniques; pharmacology of nitrous oxide; and nitrous oxide techniques and training in selection of pain control modalities should be included, if available.

3. Submit verification of current certification in basic or advanced cardiac life support. The verification should be a notarized copy of your current certification.

4. Currently no examination is available regarding the administration of nitrous oxide.

5. Upon completion of all requirements, a permanent certification in the administration of nitrous oxide analgesia will be issued. It will remain active as long as your dental hygienist license is active.

GENERAL INFORMATION

1. NAME AND/OR ADDRESS CHANGES: If your name and/or address changes please notify the Board of Dentistry in writing. To change a name or address, you can download the Data Change/Duplicate License Request Form from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.

2. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Dentistry in writing to request a refund.

ORIGINAL LICENSES ARE VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE FOR A THREE-YEAR PERIOD.

Michigan Department of Community Health
Board of Dentistry
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

DCH/LDN-021 (07/04)

APPLICATION FOR REGISTRATION BY ENDORSEMENT

Authority: Public Act 368 of 1978, as amended
if this form is not completed, a license will not be issued.

Type or Print Only

Board Use Only
License Number
Date of Licensure

I AM APPLYING FOR THE FOLLOWING:

- ☐ **Dental Hygienist Registration by Endorsement Fee: $45.00 71-2901-09**
- ☐ **Local Anesthesia Certification Fee: $10.00 71-2902-11**
- ☐ **Nitrous Oxide Analgesia Certification Fee: $10.00 71-2902-11**

Your check or money order drawn on a U.S. Financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Daytime Telephone Number ( )
Street Address		
City	State	ZIP Code
All Previous Names and/or Birth Name Used (if applicable)		

Have you ever held a health professional license in Michigan?

☐ No ☐ If yes, list Michigan permanent I.D./license number and expiration date: _____

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony?	☐ Yes	☐ No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	☐ Yes	☐ No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	☐ Yes	☐ No
4. Have you been treated for substance abuse in the past 2 years?	☐ Yes	☐ No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	☐ Yes	☐ No
6. Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?	☐ Yes	☐ No
7. Have you ever had a federal or state health professional license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	☐ Yes	☐ No
8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified?	☐ Yes	☐ No

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

9. Do you hold or have you ever held a license for your profession (other than an educational, temporary or limited license) in any state? If yes, list each state, the license number, the date issued, and how the license was obtained (either endorsement or examination). **You must have each state board** verify **licensure directly to this board office. (Attach additional sheets if necessary.)** ☐ Yes ☐ No

State	License Number	Date of Issue	How obtained (Endorsement or examination)

10. Have you previously applied for licensure to the Michigan Board? ☐ Yes ☐ No

11. Name the state from which you are endorsing: _____

12. What examination did you take to obtain licensure?

REGIONAL BOARD: (If NERB, list date of exam) _____

STATE CONSTRUCTED: List state and date of exam _____

Provide complete chronological record of your educational preparation. Attach additional sheets if necessary.

Name and Address of Institution	Dates of Attendance From	To	Degree

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date

Michigan Department of Community Health
Board of Dentistry
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

ENDORSEMENT CERTIFICATION

Authority: Public Act 368 of 1978, as amended
if this form is not completed, a license will not be issued.

SECTION I - APPLICANT INFORMATION

Instructions: Complete Section I. Type or print your name exactly as it appears on your application. Send this form to the state licensing agency for completion of Section II. This certification must be submitted directly to the Michigan Board of Dentistry by the state licensing agency where you were originally licensed.

First Name	Middle Name	Last Name
Social Security Number		Date of Birth
Street Address		
City		
State		ZIP Code
Daytime Phone Number	All Previous Names and/or Birth Name Used (if applicable)	

Professional School Attended
Street Address
City
State
ZIP Code

Signature of Applicant	Date

Applicant: Upon completion of Section I, send to the licensing agency in the state from which you are endorsing for completion of Section II on Page 2 of this form.

Name

THIS SIDE TO BE COMPLETED BY THE LICENSING AGENCY IN THE STATE FROM WHICH THE APPLICANT IS ENDORSING

SECTION II - CERTIFICATION OF LICENSE INFORMATION

Please complete the following noting any exceptions to the information requested. Return this completed certification directly to the Michigan Board of Dentistry at the address shown on the reverse side of this form.

Applicant's Name as Licensed	
License Number	Date Issued
License Status	Expiration Date

1. Has the applicant incurred any disciplinary proceedings in your state? (Please attach certified copies of any actions.) ☐ Yes ☐ No
2. Are disciplinary proceedings pending? ☐ Yes ☐ No
3. Has the applicant's license ever been limited, denied, surrendered, suspended or revoked? (Please attach certified copies of any actions.) ☐ Yes ☐ No

EXAMINATION INFORMATION

Licensure requirements in effect at the time applicant was licensed in your state:

☐ Degree

☐ Accredited School

☐ National Board Exams

☐ Licensure Exam - Please Specify ☐ Regional ☐ State Constructed

☐ Other: Please Specify _____

Dates of Examination

Name

WRITTEN/COMPREHENSIVE EXAMINATION

EXAMINATION SUBJECT	TOTAL POSSIBLE POINTS	APPLICANT'S SCORE	EXAMINATION SUBJECT	TOTAL POSSIBLE POINTS	APPLICANT'S SCORE

CLINICAL EXERCISES EXAMINATION

EXAMINATION SUBJECT	TOTAL POSSIBLE POINTS	APPLICANT'S SCORE	EXAMINATION SUBJECT	TOTAL POSSIBLE POINTS	APPLICANT'S SCORE

What was the passing score that was in effect at the time the above examination was taken?

Please describe the criteria used to determine the passing level:

Authorized Signature

Date of Signature

Print or Type Name and Title

State Board

(S E A L)

Michigan Department of Community Health
Board of Dentistry
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

VERIFICATION OF LOCAL ANESTHESIA ADMINISTRATION TRAINING

Authority: Public Act 368 of 1978, as amended

SECTION I - APPLICANT INFORMATION

Applicant Please complete the information in Section I and mail this form to the school where you trained in the didactic and clinical administration of local anesthesia.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Michigan Permanent I.D. Number and Expiration Date
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

Applicant's Signature	Date

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE PROGRAM DIRECTOR FOR COMPLETION OF SECTION II.

THIS SIDE TO BE COMPLETED BY THE PROGRAM DIRECTOR

INSTRUCTIONS FOR COMPLETING SECTION II:

The applicant listed on the previous page is seeking certification to administer local anesthesia in Michigan. Please complete Section II and the certification below concerning training received by the applicant. When the form is complete, mail it directly to the Board of Dentistry at the address shown on page 1 of this form.

SECTION II - VERIFICATION OF TRAINING

Name of School		Telephone Number
Street Address		
City	State	ZIP Code
Dates of Training From:	To:	

CERTIFICATION

I certify that _____ has completed
(Applicant's Name)

a minimum of 15 hours of didactic instruction and 14 hours of clinical experience. The following topics were covered in the training. Please check all that apply:

_____ Theory of pain control

_____ Selection of pain control modalities

_____ Anatomy

_____ Neurophysiology

_____ Pharmacology of local anesthesia

_____ Pharmacology of vasoconstrictors

_____ Psychological aspects of pain control

_____ Systemic complications

_____ Techniques of maxillary anesthesia

_____ Techniques of mandibular anesthesia

_____ Infection control

_____ Local anesthesia medical emergencies

_____
Authorized Signature (Dean, Registrar, etc.)

_____
Date

(S C H O O L S E A L)

_____
Type or Print Name and Title

Michigan Department of Community Health
Board of Dentistry
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

VERIFICATION OF NITROUS OXIDE ANALGESIA TRAINING

Authority: Public Act 368 of 1978, as amended

SECTION I - APPLICANT INFORMATION

Applicant Please complete the information in Section I and mail this form to the school where you trained in the didactic and clinical use of nitrous oxide analgesia.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Michigan Permanent I.D. Number and Expiration Date
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

Applicant's Signature	Date

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE PROGRAM DIRECTOR FOR COMPLETION OF SECTION II.

THIS SIDE TO BE COMPLETED BY THE PROGRAM DIRECTOR

INSTRUCTIONS FOR COMPLETING SECTION II:

The applicant listed on previous page is seeking certification to administer nitous oxide analgesia in Michigan. Please complete Section II and the certification below concerning training received by the applicant. When the form is complete, mail it directly to the Board of Dentistry at the address shown on page 1 of this form.

SECTION II - VERIFICATION OF TRAINING

Name of School		Telephone Number
Street Address		
City	State	ZIP Code
Dates of Training From:	To:	

CERTIFICATION

I certify that _____ has completed a minimum
(Applicant's Name)

of 4 hours of didactic instruction and 4 hours of clinical experience in the administration of nitrous oxide analgesia.

The following topics were covered in the training. Please check all that apply:

_____ Nitrous oxide analgesia medical emergency techniques

_____ Pharmacology of nitrous oxide

_____ Nitrous oxide techniques

_____ Selection of pain control modalities (if available)

_____ _____

Authorized Signature (Dean, Registrar, etc.) Date

_____ (S C H O O L S E A L)

Type or Print Name and Title

OHS/HLD-001 (01/04)

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.

- ☐ Chiropractic
- ☐ Counseling
- ☐ Dentistry
- ☐ Marriage & Family Therapy
- ☐ Medicine
- ☐ Nursing
- ☐ Nursing Home Adm.
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Osteopathy
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Physician's Assistants
- ☐ Podiatry
- ☐ Psychology
- ☐ Sanitarians
- ☐ Social Work
- ☐ Veterinary

First Name	Middle Name	Last Name
Previous Names Used	**Date of Birth**	**U. S. Social Security Number**
State Board	**License Number**	**Date of Issue**

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Basis for Issuance of License:
☐ Examination - Please indicate type of exam (National, Regional, State, etc.)
☐ Endorsement - Please indicate name of state

Type of License:

License Status	Original Issue Date	Expiration Date
☐ Current ☐ Lapsed ☐ Inactive		

Has the applicant incurred any formal or informal actions in your State?
☐ No ☐ Yes - If Yes, Please attach certified copies of any actions.

Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?
☐ No ☐ Yes	☐ No ☐ Yes

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

_____ _____
Signature **Date**

_____
Type or Print Name

(S E A L)

_____
Title

_____
Full Name of Licensing Board

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.